MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11461

CERTIFICATE OF DEATH

11418

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pleasantville
c. LENGTH OF STAY IN 1b: 60 yrs ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pleasantville X
d. STREET ADDRESS: Fallston RD 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Dora — Middle Benson — Last AMOSS

4. DATE OF DEATH: October 27 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 7–1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Unpereo Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Melchoir F Benson
14. MOTHER'S MAIDEN NAME: Rachael Jane Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address: L Willard Comoss Fallston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Cardio-vascular disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Osteoarthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1930, to Oct. 27, 1930, that I last saw the deceased alive on Oct. 25, 1960, and that death occurred at 7:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D.
ADDRESS (Street, city or town, state): Forest Hill, Maryland
DATE SIGNED: 10/27/60

PHYSICIAN'S NAME (Type): Willard P. Hudson,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 29-60
22c. NAME OF CEMETERY OR CREMATORY: Friendship
22d. LOCATION (City, town, or county) (State): Fallston Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Martin Klutz
ADDRESS: Jarrettsville Md
24a. REC'D BY REGISTRAR DATE: OCT 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11441 Item 7 F3 1m6274 11-7-60 et 11420

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 322 Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle Last BARKER

4. DATE OF DEATH: Month OCT. Day 27 Year 1960

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1901

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser (Clothes)

10b. KIND OF BUSINESS OR INDUSTRY: Cleaning Plant

11. BIRTHPLACE (State or foreign country): Oxford N.C

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles E. Barker

14. MOTHER'S MAIDEN NAME: No Record (died after His Birth)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 246-10-6168

17. INFORMANT: Mr. Reginald Tildon Address: 320 Market St Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26 1960, to 10-27 1960, that (I) (we) last saw the deceased alive on 10-27 1960, and that death occurred at 2:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. K. [illegible] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/26/60

22c. PHYSICIAN'S NAME (Type): E. J. Simon

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/30/60

23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery

23d. LOCATION (City, town, or county) (State): Swan Creek, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Bullock ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE NOV 2 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1B (4) TSM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11421

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore 24
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Whiteford

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: 3V 01-47
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore 24
d. STREET ADDRESS: 508 S. EASTERN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Katherine — Last: Boyce

4. DATE OF DEATH: Month: October — Day: 30 — Year: 1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W		MAR 30, 1904	56 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABOR	MARTIN CO.	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE C. STAHL	PRELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO			EDW. W. BOYCE	508 S. EAST AVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion 420.1	
DUE TO	(b)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO	(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Bel Air, Md — DATE SIGNED: 10-30-60

EXAMINER'S NAME (Type): Gerald C Palmer - MD

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	11/2/60	OAK LAWN	COCKEYSVILLE MD

23. FUNERAL DIRECTOR — ADDRESS	24a. REC'D BY REGISTRAR — DATE	24b. REGISTRAR'S SIGNATURE
ULRICH FUNERAL HOME - W'TOBEL AIR	NOV 3 '60	Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11463 11422

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Chandler
4. DATE OF DEATH Month Oct. Day 22 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan. 1 1875
9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Phila, Penna
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Wm. E. Chandler
14. MOTHER'S MAIDEN NAME Rachel A. Vaughton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-22-1501A
17. INFORMANT Address Mrs. Charles Chandler

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Condition Darlington Md — INTERVAL BETWEEN ONSET AND DEATH 1 hr
DUE TO (b) Arteriosclerosis — 3 yrs
DUE TO (c) ✓
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ✓ 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 10 1960 to Oct 28 1960, that (I) (we) last saw the deceased alive on Oct 26 1960, and that death occurred at 2 A M, from the causes and on the date stated above.

22a. SIGNATURE F. F. Sinsgrass M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Oct 29/60
22c. PHYSICIAN'S NAME (Type) F F Sinsgrass MD
22d. ADDRESS Darlington Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Oct. 30, 1960
23c. NAME OF CEMETERY OR CREMATORY Darlington Cem
23d. LOCATION (City, town, or county) (State) Harford Md

24. FUNERAL DIRECTOR'S SIGNATURE H R Bailey
ADDRESS Darlington, Md.
25a. REC'D BY REGISTRAR DATE NOV 1 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11442

CERTIFICATE OF DEATH

11423

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 38 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 653 Franklin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: E. Last: Collins

4. DATE OF DEATH: Month: 10 Day: 25 Year: 60 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/27/1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Samuel Ginn Edgewood, Md

11. BIRTHPLACE (State or foreign country): Boston Mass.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Hugh J. Collins

14. MOTHER'S MAIDEN NAME: Catherine Malanphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 1905 to 1919

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Joseph Collins — Address: 158 Franklin St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY OEDEMA — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
420.1
DUE TO (b): CORONARY OCCLUSION — 1 HOUR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): MYOCARDITIS & CARDIAC FAILURE — 1 YEAR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC GASTRITIS & PEPTIC ULCERS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1952, to October, 1960, that I last saw the deceased alive on Oct 25, 1960, and that death occurred at 2-1 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Wolbert M.D. — ADDRESS (Street, city or town, state): Havre de Grace Maryland — DATE SIGNED: 10/26/60

PHYSICIAN'S NAME (Type): FRANK WOLBERT M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/28/60

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Jennings Bros. — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: OCT 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11464

CERTIFICATE OF DEATH

11424 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Forest Hill
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer Creek Church Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Forest Hill
d. STREET ADDRESS: Deer Creek Church Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Sarah Middle: Alice Last: Crouse
4. DATE OF DEATH: Month: October Day: 18, Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 28, 1884
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeper
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U. S. A

13. FATHER'S NAME: Haywood Estep
14. MOTHER'S MAIDEN NAME: Matilda Billings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT (Son): Earle Crouse Address: Forest Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chr. Cardio-Vascular disease — 12 yrs?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 20, 1927, to Oct 18, 1960, that I last saw the deceased alive on Oct 5, 1960, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 10/19/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 21, 1960
22c. NAME OF CEMETERY OR CREMATORY: Deer Creek Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Forest Hill, Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster ADDRESS: W. Broadway & Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 24 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Frew

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11443 — 11425

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: 622 Stokes, St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Anna — Last: CULLUM
4. DATE OF DEATH: Month: 10 — Day: 16 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/30/1886
9. AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Dameron
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Eve Gibson, Havre-de-Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10/14/ 1960 to 10/16/ 1960, that (I) (we) last saw the deceased alive on 10/14/ 1960 and that death occurred at __ M. from the causes and on the date stated above

22a SIGNATURE: Chas L. Wadsworth M.D. — ATTENDING PHYS X — MED DIRECTOR ☐ — STAFF PHYS. ☐
22b DATE SIGNED: 10/16/60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: 10/19/60
23c NAME OF CEMETERY OR CREMATORY: Rock Run
23d LOCATION (City, town or county) (State): Rock Run Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington Bros Havre de Grace Md
25a. REC'D BY REGISTRAR DATE: OCT 20 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11444 — 11426

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora Maryland Rural
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Harvey — Middle Thomas — Last Davis

4. DATE OF DEATH: Month October — Day 14 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 2-19-1870

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Bookkeeper

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Davis

14. MOTHER'S MAIDEN NAME: Dora Culbertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213 12 3852

17. INFORMANT: Charles Davis — Address: 8325 Stone Road Delair N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Comminuted Fracture Right Femur +

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19___, to _____ 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Frank D. Hauber, M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10-14-60

22c. PHYSICIAN'S NAME (Type): Frank D. Hauber

22d. ADDRESS: 645 S. Union St. Havre de Grace Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-11-1960
23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
23d. LOCATION (City, town, or county) (State): Colora, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Elmore E. Millikan Rising Sun Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: OCT 18 60
25b. REGISTRAR'S SIGNATURE: Arthur S. Rhine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11445 11427

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace

c. LENGTH OF STAY IN 1b: X

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

d. STREET ADDRESS: R.D. #2, Box 182

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Albert Middle Gerard Last DeBey

4. DATE OF DEATH: Month 10 Day 23 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Mar. 8, 1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Electronics

11 BIRTHPLACE (State or foreign country): Iowa

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Gerard deBey

14. MOTHER'S MAIDEN NAME: Nina Lee Creiger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 153-01-1376

17 INFORMANT: Mrs. L. de Bey Address: R.D. 2 Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: IMMED

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a m p m Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from JAN, 1960 to OCT 23, 1960, that (I) (we) last saw the deceased alive on OCT 16 1960 and that death occurred at 4P M. from the causes and on the date stated above

22a SIGNATURE: Dudley Phillips MD M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 10/24/60

22c PHYSICIAN'S NAME (Type): Dudley Phillips MD

22d. ADDRESS: DARLINGTON, Md

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 10/26/60

23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, Bel Air, Maryland

23d LOCATION (City, town, or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring

ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a REC'D BY REGISTRAR DATE: OCT 27 '60

25b REGISTRAR'S SIGNATURE: Clifton S. Kinna

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) ISM 9/59

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11446 — 11428

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 833 Ontario St
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home de Grace

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MD — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 833 ONTARIO
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louisa — Middle: Werner — Last: Eddowes
4. DATE OF DEATH: Month: October — Day: 13 — Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APR. 20, 1863
9. AGE (In years last birthday): 97 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John WERNER
14. MOTHER'S MAIDEN NAME: REGINNA SISTLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Louise K. Gorsuch. Address 833 ONTARIO, ST HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic CV disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

+22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bel Air, md

DATE SIGNED: 10-13-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 15, 1960
22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.
22d. LOCATION (City, town, or country) (State): HAVRE DE GRACE, MD

23. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE, MD
24a. REC'D BY REGISTRAR: DATE OCT 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11465

11429

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel-Air Rfd.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel-Air R. D.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Amanda — Middle: F. — Last: Edwards

4. DATE OF DEATH: Month: Oct. — Day: 2 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER-MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 11 1872

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework at Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sparta N. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Adam Hagers

14. MOTHER'S MAIDEN NAME: Nancy Caudill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Not (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lenny Edwards — Address: Forest Hill Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 30 1960, to Oct. 2 1960, that (I) (we) last saw the deceased alive on Sept. 30 1960, and that death occurred at 5a.M, from the causes and on the date stated above

22a. SIGNATURE: Willard P. Hudson M.D.

ATTENDING PHYS X ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Oct. 2, 1960

22c. PHYSICIAN'S NAME (Type): Willard P. Hudson

22d. ADDRESS: Forest Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: Oct 4 1960

23c. NAME OF CEMETERY OR CREMATORY: Mem'l Park

23d. LOCATION (City, town, or county) (State): Sparta, N. C.

24. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey

ADDRESS: Darlington Md.

25a. RECD BY REGISTRAR DATE: OCT 5 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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11447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11430

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Bel Air Rural~~ 315 E. Lorraine Ave.
d. STREET ADDRESS ~~Kirkwin Convalescent Home~~ Bel Air, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cora Middle Hanna Last Forwood
4. DATE OF DEATH: Month October Day 27 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 2, 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Shoesales
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James O. Forwood
14. MOTHER'S MAIDEN NAME: Susan Hanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Nephew): Mr. Orem F. Hubbard — Address: Oxford, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Old Age
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 22, 1960, to Oct 27, 1960, that (I) (we) last saw the deceased alive on October 27 1960, and that death occurred at 10:? M, from the causes and on the date stated above

22a. SIGNATURE: Dudley Phillips MD — M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/28/60
22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD
22d. ADDRESS: Darlington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 29, 1960
23c. NAME OF CEMETERY OR CREMATORY: Centre Methodist Cemetery
23d. LOCATION (City, town, or county) (State): Forest Hill, Harford Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 31 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11448 11431

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b 26 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE Maryland b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
d. STREET ADDRESS 666 GREEN St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LESLEY Middle Hopper Last GALLOWAY

4. DATE OF DEATH Month October Day 30 Year 19 60

5. SEX MALE

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 11/21/1887

9. AGE (In years last birthday) 73 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Farm. City

11. BIRTHPLACE (State or foreign country) MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David O. GALLOWAY

14. MOTHER'S MAIDEN NAME Alice WILLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis in abdomen — INTERVAL BETWEEN ONSET AND DEATH 2 months

DUE TO (b) Carcinoma of Ampula of Vater — 7 months

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 155.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year 19 Hour o m. p m

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10/4th, 1960 to 10/30, 1960 that (I) ~~(we)~~ last saw the deceased alive on 10/30/1960 and that death occurred at 12 30 A M, from the causes and on the date stated above.

22a SIGNATURE Edward C. Loo M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED 10/30/60

22c PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.

22d. ADDRESS 211 N. Union Ave., Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF 11/1/60

23c NAME OF CEMETERY OR CREMATORY Angel Hill

23d LOCATION (City, town or county) (State) Md. Havre de Grace Md.

24 FUNERAL DIRECTOR'S SIGNATURE Thompson & Son ADDRESS Havre de Grace Md.

25a REC'D BY REGISTRAR DATE NOV 1 '60

25b REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11438 — 11432 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 8 S. Rogers Street

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d STREET ADDRESS: 8 S. Rogers Street
e IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First E. Middle RUBENA Last GIBSON
4. DATE OF DEATH: Month October Day 9 Year 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 25, 1868
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (State or foreign country): Penna.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Humphrey Corson
14. MOTHER'S MAIDEN NAME: Elma Ann Bowman
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lee Mitchell, Address Foley Road, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerotic Heart Disease — 3 YEARS
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1958 19___ to Oct 8 19 60 that I last saw the deceased alive on Oct 8 -60 19___, and that death occurred at 10:00 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Andre Weiss M.D.
ADDRESS (Street, city or town, state): 114 W. Bel Air Ave, Aberdeen, Md.
DATE SIGNED: 10-10-60
PHYSICIAN'S NAME (Type): Andre Weiss, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/60
22c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: John G Tarring
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
John G. Tarring
24a. REC'D BY REGISTRAR DATE OCT 13 '60
24b. REGISTRAR'S SIGNATURE: Clifton E Travis

1 43

FOR STATE HEALTH DEPT.

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11466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11433

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): DARLINGTON
c. LENGTH OF STAY IN 1b: IN CAR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1½ miles N.E on Castleton, Rd

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Bel Air (Baltimore)
d. STREET ADDRESS: Box 184 (316- 20th Street)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EARLE Middle ANDREW Last GREENE
4. DATE OF DEATH: Month OCTOBER Day 15 Year 1960

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 23, 1928
9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHEMIST
10b. KIND OF BUSINESS OR INDUSTRY: Army Chemical Center
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLARK GREENE
14. MOTHER'S MAIDEN NAME: BERTHA NORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO: 162-067-062
17. INFORMANT: Mrs. Cathleen Green Address: Box 120 Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): BRAIN INJURY — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
9764
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): SHOTGUN BLAST BLEW OFF TOP OF HEAD
DUE TO (c): SUICIDE

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): SUICIDE - PLACED 12 gauge shotgun to RIGHT TEMPLE
20c. TIME OF INJURY Hour a. m. Month Day Year: 11:30 — OCT 15 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): CASTLETON Rd
20f. (City or town) (County) (State): DARLINGTON, HARFORD, Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-18-60
22c. NAME OF CEMETERY OR CREMATORY: FAWN ZION A.M.E. Cemetery
22d. LOCATION (City, town, or county) (State): FAWN Grove, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock, Havre de Grace, Md
ADDRESS: 556 Lewis St
24a. RECD BY REGISTRAR DATE: OCT 18 '60
24b. REGISTRAR SIGNATURE: Arthur S. Travis

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11449 — 11434

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH — a. COUNTY: HARFORD — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
d. STREET ADDRESS: 12 Baltimore St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Elizabeth — Last: Gross
4. DATE OF DEATH: Month: October — Day: 24 — Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/7/12
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cost Accounting Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E Gross
14. MOTHER'S MAIDEN NAME: Mary (Mitchell) Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/22 1960 to 10-24 1960 that (I) (we) last saw the deceased alive on 10-24 1960 and that death occurred at 10:58 M. from the causes and on the date stated above

22a. SIGNATURE: A.L. Lewis M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/25/60
22c. PHYSICIAN'S NAME (Type): A.L. Lewis
22d. ADDRESS: 214 N. Union Ave. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/27/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
23d. LOCATION (City, town or county) (State): R.D. Bel Air, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md,
John G. Tarring
25a. REC'D BY REGISTRAR DATE: OCT 27 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11467 — 11435

Item 4 - Film 6274 11-4-60 et

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ~~206 Mallow Hill Road~~ Harford Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 206 Mallow Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY — Middle: I. — Last: GROVE

4. DATE OF DEATH: October 28, 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1875

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Anderson

14. MOTHER'S MAIDEN NAME: ? Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Richard W. Grove — Address: 206 Mallow Hill Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b): Hypertensive Cardiovascular Dis. — 7 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-28-60 to 10-28-60 that (I) (we) last saw the deceased alive on 10-28-1960 and that death occurred at 12:15 P.M. from the causes and on the date stated above

22a. SIGNATURE: Clifford F. Hudson M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON — 22d. ADDRESS: FORK, MD.

23a. BURIAL CREMATION REMOVAL (Specify): Burial — 23b. DATE THEREOF: 10/31/60 — 23c. NAME OF CEMETERY OR CREMATORY: Deudon Park Cemetery — 23d. LOCATION (City, town, or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J Tickner & Sons Inc — ADDRESS: Balto Md North & Penna

25a. REC'D BY REG STRAR DATE: OCT 31 '60 — 25b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11439 — 11436 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
c. LENGTH OF STAY IN 1b: 6 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 34 IDLEWILD

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS: 34 IDLEWILD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle RAYMOND Last JACKSON
4. DATE OF DEATH: Month OCTOBER Day 21 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB 6, 1921
9. AGE (In years last birthday): 39 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INVALID - ARMY
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NORMAN JACKSON
14. MOTHER'S MAIDEN NAME: ETTA TEAGUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO:
17. INFORMANT: MRS ETTA L. JACKSON Address: 34 IDLEWILD BEL AIR, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE RT. CEREBAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN
332
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PARALEGIC FOR 10 YRS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): AUTO
20c. TIME OF INJURY Hour a m: 10:00 — Month, Day, Year: MAY 27 19 50
20d. INJURY OCCURRED White at work ☐ Not white at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HIGHWAY 67
20f. (City or town) OUTSIDE OF CAIRO, (County) (State) ILL.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN M.D
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct 21, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: October 24, 1960
22c. NAME OF CEMETERY OR CREMATORY: Fork Christian Cemetery
22d. LOCATION (City, town, or county) (State): Sunshine Ave., Fork, Harford Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR, DATE: OCT 24 '60
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11450

11437

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 9½ HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d STREET ADDRESS: Box 278 A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Kuhn

4. DATE OF DEATH: Month: October — Day: 20 — Year: 19 60

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-20-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: 9 — Min: 23

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Albert V. Kuhn

14. MOTHER'S MAIDEN NAME: KATE Lillian Roberts

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Kate L. Kuhn — Address: Abingdon Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atelectasis
DUE TO (b): Prematurity
DUE TO (c): Placenta Praevia

761.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 8 hours.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10/22, 19 60 to 10/22, 19 60 that (I) (we) last saw the deceased alive on 10/22 19 60 and that death occurred at 10:55 P.M. from the causes and on the date stated above

22a SIGNATURE: Wm. Allan M Leen M D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYS CIAN'S NAME (Type) WM. M. LEEN

22d ADDRESS: 600 S. Union Ave. Havre de Grace. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Oct. 24, 1960

23c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial

23d. LOCATION (City, town, or county) (State): Abingdon, Harford, Md.,

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K McCann Jr

ADDRESS: Abingdon, Md.,

25a. REC'D BY REG STRAR DATE OCT 26 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2271336 KV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

11451

11438

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH a. COUNTY: Harford MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN 1b: 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham, Pa. Rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial	d. STREET ADDRESS: 07 X-? — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First: Bessie Middle: Lou Last: Loggins	4. DATE OF DEATH Month: October Day: 13 Year: 1960
5. SEX: Female — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 11/2/16 — 9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): N. Carolina — 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Reed Hill	14. MOTHER'S MAIDEN NAME: Pearl (McMillan) Hill
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO: 197-12-2488	17. INFORMANT: Charles Loggins Address: Nottingham, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible]

453.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ______ 19__ to 10-13 1960 that (I) (we) last saw the deceased alive on 10-13 1960 and that death occurred at 12:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: [illegible signature] M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒ — 22b. DATE SIGNED: 10-13-60.

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS: Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	10-16-1960	Tome bridge Baptist	Rising Sun, Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[illegible] E. McMullen	Rising Sun, Md.	DATE OCT 18 '60	[illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be re[illegible]ned by the hospital or attending physician. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VR A15 (4) 15M 8/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11452

CERTIFICATE OF DEATH

11439
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last MAHAN
4. DATE OF DEATH Month October Day 16, Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 25, 1870
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin Mahan
14. MOTHER'S MAIDEN NAME Susan Hunter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO 218-28-4630
17. INFORMANT (Daughter) Address Mrs. Mason A. Wilson Rock Spring Road Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 15 min.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary artery disease
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Carcinoma of colon
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 28, 1960, to Oct. 16, 1960, that I last saw the deceased alive on Oct. 15, 1960, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Willard P. Hudson M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED 10-17-60

PHYSICIAN'S NAME (Type) Willard P. Hudson Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF October 19, 1960
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Catholic Church Cemetery
22d. LOCATION (City, town, or county) (State) Hickory, Harford County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE OCT 18 '60
24b. REGISTRAR'S SIGNATURE Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11453

CERTIFICATE OF DEATH

11440

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d. STREET ADDRESS: 136 S. Philadelphia Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Dorothy — Middle: P. — Last: MALOUKAS

4. DATE OF DEATH: Month: October — Day: 10 — Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 18, 1897
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Paluisonoff
14. MOTHER'S MAIDEN NAME: Persontone (Unknown).

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: 056 12 7568
17. INFORMANT: Louis Maloukas, 136 S. Phila. Blvd. Address: Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b): Cerebral arteriosclerosis — 5 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Sept 1 19 59 to Oct 10, 1960, that (I) (we) last saw the deceased alive on Oct 10 1960, and that death occurred at 4:25 P.M. from the causes and on the date stated above

22a. SIGNATURE: E. J. Plunkett Jr. M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): E.J. Plunkett Jr., M.D.
22d ADDRESS: 617 W. Bel Air Ave, Aberdeen, Md.

23a. BUR A. CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 10/13/60
23c NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
23d LOCATION (City, town, or county) (State): R.D. 2, Aberdeen, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John E. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.
25a. RECD BY REGISTRAR DATE: OCT 14 '60
25b. REGISTRAR'S SIGNATURE: Esther L. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11454 Item 13 filmed 12-7-60 C. 11441

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 90 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: Box 691 Old Phila Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James Middle Clark Last McManus

4. DATE OF DEATH: Month 10 Day 3 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 5, 1906

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Kentucky

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Williams McManus

14. MOTHER'S MAIDEN NAME: Veronia (Scott) McManus

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) Yes 9-7-37

16 SOCIAL SECURITY NO: 220-05-7202

17 INFORMANT: Mrs. Margaret McManus Address: Box 691 Old Phila. Rd. Joppa, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive cardio-vascular disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Biliary Fistula

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 4 1960 to Oct 2 1960 that (I) (we) last saw the deceased alive on Oct 1 1960 and that death occurred at 5 P.M. from the causes and on the date stated above

22a SIGNATURE: James McC. Finney M.D

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 10-5-1960

23c. NAME OF CEMETERY OR CREMATORY: St. Stephen's

23d LOCATION (City town, or county) (State): Bradshaw, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lassahn Funeral Home 7401 Belair Rd.

25a. REC'D BY REGISTRAR DATE OCT 5 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Koons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M II/59

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11455

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11442

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 606 Green St.

3. NAME OF DECEASED (Type or print): First: Alice — Middle: D — Last: McMaster

4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 24 1869

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McMaster

14. MOTHER'S MAIDEN NAME: Susanna Schritz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Harry J. Crawford — Address 606 Green St Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO (b): Hypertension arterio sclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10-8, 1960, to 10-8, 1960 that (I) (we) last saw the deceased alive on 10-8-1960, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E. J. Simon M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-8-60

22c. PHYSICIAN'S NAME (Type): E. J. SIMON

22d. ADDRESS: Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Oct 11, 1960

23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM

23d. LOCATION (City, town, or county) (State): HAVRE DE GRACE MD

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD

25a. REC'D BY REGISTRAR — DATE: OCT 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11456

CERTIFICATE OF DEATH

11443

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace

c. LENGTH OF STAY IN 1b 10-21-60 (4 days)

d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. — b. COUNTY Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Havre de Grace

d STREET ADDRESS 1 N O # 2

e IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Kathleen Middle M. Last Mitchell

4. DATE OF DEATH Month October Day 25, Year 1960

5 SEX Female

6. COLOR OR RACE white

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH 4-15-52

9. AGE (In years last birthday) 8 yrs

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10b KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Mitchell

14. MOTHER'S MAIDEN NAME Evalee Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Mitchell — name (father) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acidosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Diabetes + Glomerulo Nephritis +

DUE TO (c) Mild Congestive Failure

INTERVAL BETWEEN ONSET AND DEATH 2-3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan 2, 19 60, to OCT 25, 19 60, that (I) (we) last saw the deceased alive on Oct 25 19 60 and that death occurred at 1:15 P M, from the causes and on the date stated above

22a. SIGNATURE Dudley Phillips MD — M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED 10/26/60

22c. PHYSICIAN'S NAME (Type) Dudley Phillips III

22d. ADDRESS Darlington, Md

23a BUR AL, CREMAT ON, REMOVAL (Specify) Burial

23b DATE THEREOF 10/28/60

23c NAME OF CEMETERY OR CREMATORY Harmony Pres. Cemetery

23d. LOCATION (City, town or county) (State) RD. Havre de Grace, Md.

24 FUNERAL DIRECTOR'S SIGNATURE John G. Tarring — ADDRESS Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE OCT 31 '60

25b. REGISTRAR'S SIGNATURE Catherine S. Krauss

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11457 — 11444

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Harf.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson
d. STREET ADDRESS: Harford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edna — Middle: S. — Last: Preston

4. DATE OF DEATH: Month: Oc — Day: 4 — Year: 19 6 0

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Apr. 28 1887

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Stanford

14. MOTHER'S MAIDEN NAME: Ellisa J. Clark — Fallston Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-12-3077

17. INFORMANT: Mrs. Dorothy Corbin — Address: Benson, Md.

MED CAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatitis & liver failure
DUE TO (b):
DUE TO (c):

5 x 3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18): liver only

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-10 1960 to 10-4 1960 that (I) (we) last saw the deceased alive on 10-4 1960, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Wm. K. Bender M.D.
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Oct-5-1960

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 7, 1960

23c. NAME OF CEMETERY OR CREMATORY: Friends Meeting

23d. LOCATION (City, town or county) (State): Fallston, Harford Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. T. Archer
ADDRESS: Benson Md

25a. REC'D BY REGISTRAR DATE: OCT 10 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11419

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 14 hrs.,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: Willoughby Beach Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Steve; Middle: Joseph; Last: Rakar

4. DATE OF DEATH: Month: Oct.; Day: 25,; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug.11,1915

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Missle

11. BIRTHPLACE (State or foreign country): Fort Palmer, Pa.,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: John Rakar

14. MOTHER'S MAIDEN NAME: Zusan Sichula

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give war or dates of service): WW 11

16. SOCIAL SECURITY NO.: 210-05-5211

17. INFORMANT: Muriel E. Rakar
Address: Edgewood Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

S16X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident

20c. TIME OF INJURY: Hour a.m. p.m.: ; Month, Day, Year: 1/24 19 60

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 40

20f. (City or town): Edgewood

(County): Harford

(State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐ Bel Air Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 10-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.28,1960

22c. NAME OF CEMETERY OR CREMATORY: St. Stephen's

22d. LOCATION (City, town, or country): Bradshaw - Balto. - Maryland.

23. FUNERAL DIRECTOR: Howard K McComas Jr

ADDRESS: Abingdon,Md.,

24a. REC'D BY REGISTRAR DATE: OCT 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11468

CERTIFICATE OF DEATH

11445 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
c. LENGTH OF STAY IN 1b: 6 mos.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: Long Bar Harbor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Antoinette — Middle: A. — Last: Raymond

4. DATE OF DEATH: Month: Oct. — Day: 5 — Year: 19 60

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 26, 1880

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Quebec Canada

12. CITIZEN OF WHAT COUNTRY? Canada ✓

13. FATHER'S NAME: Joseph Morissette

14. MOTHER'S MAIDEN NAME: Mulvina Dumas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph D. Caron — Address: Abingdon Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis, C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO (b): Hypostatic Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 10, 19 60, to ~~Sept 29~~ Oct 5 19 60 that I last saw the deceased alive on Sept 29, 19 60, and that death occurred at 11:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D. — ADDRESS (Street, city or town, state): 114 W. Bel Air Av. — DATE SIGNED

PHYSICIAN'S NAME (Type): ANDRE WEISS MD — Aberdeen, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: Oct. 6, 1960 — 22c. NAME OF CEMETERY OR CREMATORY: Edgar J. Racicot, Inc., — 22d. LOCATION (City, town, or county) (State): Lawrence, Essex Co., Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McCormick Jr — ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: OCT 10 '60

24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11469 — 11446

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 22

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2711 Gilford Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Robert Last: Rinehart (Sr.)

4. DATE OF DEATH: Month: October Day: 13 Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-3-42

9. AGE (In years last birthday): 17 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Robert Rinehart Sr.

14. MOTHER'S MAIDEN NAME: Helen N. Wojciechowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-38-8290

17. INFORMANT (Father): Joseph Robert Rinehart Address: 2711 Gilford Ave Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH:

822X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY: Hour 9:15 a.m. p.m. Month, Day, Year: 10-13 19 60

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 22 (City or town): Bel Air (County): Harford (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Harold E Palmer M.D.

EXAMINER'S NAME (Type): Harold E Palmer MD

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Bel Air, Md

DATE SIGNED: 10-13-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: October 17, 1960

22c. NAME OF CEMETERY OR CREMATORY: St John's Cemetery

22d. LOCATION (City, town, or country) (State): Long Green, Balto. County, Maryland

23. FUNERAL DIRECTOR: Joseph T. Foster ADDRESS: W. Broadway & Williams St Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kness

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11470 11447

1. PLACE OF DEATH
a. COUNTY Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD Cardiff Whiteford
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff
d. STREET ADDRESS Chestnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Riley Middle: W. Last: Rudd

4. DATE OF DEATH Month: October Day: 27 Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-18-05

9. AGE (In years last birthday) 55 yrs.
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Greenbrier, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John R. Rudd

14. MOTHER'S MAIDEN NAME: Sara Booth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-07-9623

17. INFORMANT: Mrs. Minnie Rudd Address: Cardiff, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound fracture skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

9101

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Tree fell on him

20c. TIME OF INJURY Hour: 5 p.m. Month, Day, Year: 10-27-1960

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): Whiteford (County): Ha (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M D

EXAMINER'S NAME (Type): Gerald C Palmer M D

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 10-28-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 30, 1960

22c. NAME OF CEMETERY OR CREMATORY: Baptist View

22d. LOCATION (City, town, or county): Aberdeen, Md. (State):

23. FUNERAL DIRECTOR: John H. Hopkins ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: OCT 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

1

FOR STATE HEALTH DEPT.

TO DEPT. / MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 273 10-17

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11459 11448

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 6 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY: YORK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELTA
d. STREET ADDRESS: R.D #1 BOX 15
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LULA — Middle MAE — Last SCARBOROUGH

4. DATE OF DEATH: Month OCTOBER — Day 1 — Year 1960

5. SEX: FEMALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: OCT. 1, 1944 — 9. AGE (In years last birthday): 15 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES SCARBOROUGH
14. MOTHER'S MAIDEN NAME: VELMA ORR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: VELMA SCARBOROUGH — Address: DELTA, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pending report from autopsy report — DUE TO
080.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Poliomyelitis — DUE TO
(c) Polio Virus, type III

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept. 30, 1960 to Sept. 30 1960 that (I) (~~we~~) last saw the deceased alive on Oct. 1st 1960 and that death occurred at 12 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/1/60
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: 211 N. Union Ave. Havre de Grace

23a. BURIAL, CREMATION OR REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 4, 1960
23c. NAME OF CEMETERY OR CREMATORY: SLATEVILLE
23d. LOCATION (City, town, or county) (State): DELTA, PA.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Harkins — ADDRESS: Delta, Pa.
25a. REC'D BY REGISTRAR DATE: OCT 5 '60
25b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11471 — 11449

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harmony Church Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS: Farm Ed Wheeler
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: David; Middle: BOWMAN; Last: Smith

4. DATE OF DEATH: Month: October; Day: 5; Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 8, 1946

9. AGE (In years last birthday): 14 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: ***

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan D. Smith

14. MOTHER'S MAIDEN NAME: Ruth Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: N.D. Smith, Darlington, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GSW cerebrum — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 919.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Run went off in auto

20c. TIME OF INJURY: Hour 3 a.m. p.m.; Month, Day, Year: 10 5 1960

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 20f. (City or town): Darlington (County): Harford (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER [ ] Bel Air Md

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 10-5-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/8/60

22c. NAME OF CEMETERY OR CREMATORY: Smith Chapel Cemetery,

22d. LOCATION (City, town, or country) (State): R.D. 2, Aberdeen, Md.

23. FUNERAL DIRECTOR: John G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: OCT 13 '60

24b. REGISTRAR'S SIGNATURE: C. Thos. L. Kraus

John G. Tarring

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11440 — 11450

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air

LENGTH OF STAY (In this place) 10 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md — COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air

STREET ADDRESS (If rural give location) 109 N. Main St.

3. NAME OF DECEASED (Type or Print) — (First) LAURA — (Middle) BELLE — (Last) TARRING

4. DATE OF DEATH (Month) OCT (Day) 2 (Year) 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W	Widowed	June 12 1885	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Practical	Nurse	Templeville Md	US

13. FATHER'S NAME: W Nathaniel Bowen

14. MOTHER'S MAIDEN NAME: Ella Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ✓ (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ✓

17. INFORMANT & ADDRESS: Mrs George P. Harrison 109 N Main St Bel Air Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

15 Sec. IMMEDIATE CAUSE (A) CARDIO-RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

ANTECEDENT CAUSE(S) DUE TO (B) METASTATIC CARCINOMA — 4 Mo

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) CARCINOMA OF COLON — 4+ Mo.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 55 ..... to 2 Oct 1960, that I last saw the deceased alive on 2 Oct 1960, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

SIGNATURE H Hadwell M.D. — ADDRESS (Street, city, town, state) 401 Franklin St Bel Air Md — DATE SIGNED 2 Oct 60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 4/60	Bel Air Memorial	Bel Air Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE OCT 4 '60	Arthur S. Evans	Joseph T Foster	Bel Air Md

Item 20 Film 274 11-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11460 11451

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gary Middle: Franklin Last: Wagoner
4. DATE OF DEATH: Month: 10 Day: 21 Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 17, 1960
9. AGE (In years ost birthday): 5wks
IF UNDER 1 YEAR: Months: 1 Days: Hours: Min:
IF UNDER 24 HRS:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Clay Wagoner
14. MOTHER'S MAIDEN NAME: Fannie E. Billings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NK
17. INFORMANT: Clay Wagoner Address: Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Strangulation — INTERVAL BETWEEN ONSET AND DEATH: (MINUTES)
DUE TO (b): Aspiration of milk in Sleep
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 921.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Apparently swallowed milk and aspirated in sleep
20c. TIME OF INJURY Hour: 4 o. m: xxx Month: Oct Day: 21 Year: 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.): home
20f. (City or town): Level (County): Harford (State): Md.

21. I certify that (I) (this hospital) attended the deceased from Sept 17, 1960, to Oct 21, 1960, that (I) (we) last saw the deceased alive on Oct 17, 1960, and that death occurred at 4:M, from the causes and on the date stated above

22a. SIGNATURE: Dudley Phillips MD M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/21/60
22c. PHYSICIAN'S NAME (Type): Dudley Phillips (MD)
22d. ADDRESS: DARLINGTON, Md

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: Oct 23, 1960
23c. NAME OF CEMETERY OR CREMATORY: Welcome Cem
23d. LOCATION (City, town, or county) (State): Harford Co, Md

24. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey ADDRESS: Darlington Md
25a. REC'D BY REGISTRAR DATE: OCT 26 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) TSM 9/59

207124XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11472

CERTIFICATE OF DEATH

11452
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PYLESVILLE
c. LENGTH OF STAY IN 1b LIFE TIME
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PYLESVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last WEBSTER, SR.
4. DATE OF DEATH Month OCT. Day 6, Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 2-2-1883
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME JOHN W. WEBSTER
14. MOTHER'S MAIDEN NAME GEORGANNA HEUISLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address John E Webster Jr. Pylesville RD, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral C-V Disease
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1960, to Oct 6, 1960, that I last saw the deceased alive on Oct 1, 1960, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Josiah A Hunt M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED OCT 7 1960
PHYSICIAN'S NAME (Type) Josiah A. Hunt, M.D. Delta, Penna.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-10-60
22c. NAME OF CEMETERY OR CREMATORY St. MARYS CATHOLIC
22d. LOCATION (City, town, or county) (State) PYLESVILLE, HARFORD CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W Reuhm
ADDRESS Stewartstown Penna.
24a. REC'D BY REGISTRAR DATE OCT 10 '60
24b. REGISTRAR'S SIGNATURE Chilling S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITA[illegible] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h[illegible] fter death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible]

VS A15 (-1)
15M 10/75

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG274 10-31-60 et

11473

CERTIFICATE OF DEATH

11453
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bel Air
c. LENGTH OF STAY IN 1b 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION White House Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Bel Air
d. STREET ADDRESS White House Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Martha Middle JANE Last WEISHEIT

4. DATE OF DEATH Month October Day 25 Year 1960

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH October 31, 1866

9. AGE (In years last birthday) 93 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Moses Guy

14. MOTHER'S MAIDEN NAME Matilda Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Mrs. Henry Weisheit Address RD #2 Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 4 days

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 15, 19 60, to Oct 25, 19 60, that I last saw the deceased alive on Oct 25, 19 60, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Chas. Richardson M.D. ADDRESS (Street, city or town, state) Bel Air Md. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 27, 1960

22c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal Cemetery

22d. LOCATION (City, town, or county) (State) Churchville, Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE OCT 28 '60

24b. REGISTRAR'S SIGNATURE Clifton L. Krauss

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.